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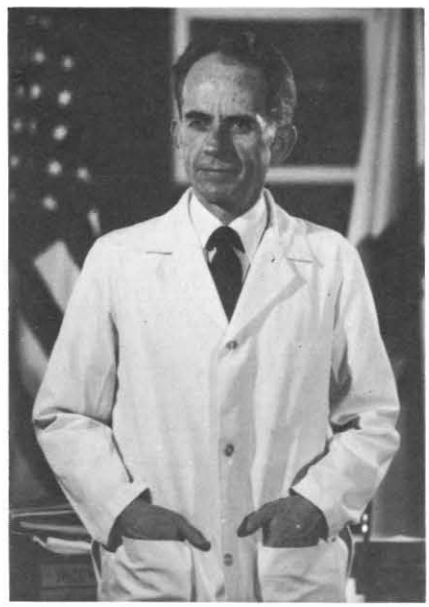
COVER: At the Surgeon General's annual conference for commanding officers, HMCM H.A. Olszak, USN, Force Master Chief, BUMED, detailed current concerns of the enlisted community. For his presentation, see page 22.

Cost Containment is a Personal Responsibility

The same pressures which have resulted in the cost of medical care in the civilian community increasing by over 1250% since 1950 are reflected just as dramatically in the increasing costs experienced in the operation of the Navy Medical Department. Changes in technology, new diagnostic and therapeutic modalities, imposition of new life and safety codes, newly mandated health surveillance programs, utility costs, wage increases, inflation, as well as heightened expectations on the part of those for whom we provide health services have all contributed to driving the total economic value of the resources we require to a level never before experienced. Unfortunately, the economic resources which have been made available to support our system have not been sufficient to meet the increased resource demand which we are experiencing; competing as they must against all government programs in these times of conflicting imperatives.



Never before has it been more vital that we in Navy medicine explore every avenue possible to reduce our costs and also to ensure that the resources we do expend are contributing maximally to providing both the quality and quantity of services necessary to accomplish our mission.

I have been impressed by the initiatives which have been taken to ensure optimal use of our resources. Many commands have formed cost containment committees at the local level. Active utility conservation programs have paid dividends far beyond even optimistic expectations in terms of fuel conservation and dollar savings. Improved inventory management has resulted in significant savings in many commands. Development of alternative cheaper sources of purchase for many of our high usage expendable items is reducing operating costs for many of our facilities.

However, it is not only at the command level that attention must be directed to cost containment. Each of us in the Medical Department, no matter what his job, must take it as a matter of personal responsibility to manage the resources he uses as carefully as possible. Look at your job. Can it be done in a manner which will save dollars or people, at the same time continuing to contribute maximum effectiveness from our efforts? I am certain, based on the resourcefulness that each of you has demonstrated so fully in the past, that an increased effort on everyone's part will provide the savings and, therefore, the resources needed to do our job.

W.P. ARENTZEN
Vice Admiral, Medical Corps
United States Navy

Surgeon General's Conference for Commanding Officers

The Surgeon General's conference for commanding officers of medical and dental commands convened this year in Arlington, Va., 13-15 Nov 1978.

This report represents an edited—sometimes paraphrased or abbreviated—version of major speakers' presentations at plenary sessions of the conference. Their remarks do not necessarily reflect official views of the Navy Department or the naval service at large.—Ed.

Opening Remarks

VADM W.P. Arentzen, MC, USN
Surgeon General of the Navy

Let me start by sharing this little aphorism with you: "Life is easier to take than you'd think: All that is necessary is to accept the impossible, do without the indispensable, and bear the intolerable." The past two years have shown me the truth of this statement.

The Medical Department has many problems—many and serious problems—but its future is bright. It has a future because that future is to a large extent in the competent hands of you, the commanding officers and senior staff.

Where are we, and where are we going?

First, let's emphasize the concept of a Medical Department. That is what we are. We should not, we must not, we cannot think primarily of "Corps." As we must think of "one Navy," putting aside preeminence of air or surface or submarine or active vice reserve, so must we subvert our just pride in "Corps" to the singular product of health care delivery that none of us can deliver alone.

"One Navy" is the watchword of the CNO. It is with considerable pleasure we note that we, as a Medical Department, anticipated him by several years.

The Medical Department's mission is unique. We must protect, defend, and justify that uniqueness. Most modern medicine is the same wherever you go. But there are things in the military that are different, and they must be preserved.

We must remain an integral separate system, because only then can we meet the current contingency scenarios. And only if we maintain full-service facilities, with teaching programs to back them up, will we have the immediately available assets that contingency would demand. We must justify, in a credible manner, all of our billets to contingency and convince the analysts of what we already know: that to say "a doctor is a doctor under any circumstances" is a fallacy.

Admiral Win Weese, in a recent presentation to DOD, refuted that statement. He said that a civilian physician cannot just drop his practice in a contingency and serve in the Navy. He must be trained—for a Navy physician must know more than his civilian counterpart. "What do we civilians know about war wounds, massive injuries, mass casualty evacuation, logistics, etc.?" he asked. "Perhaps we have placed too much emphasis on how similar we are to civilian medicine—especially in our hospital environment."

We must emphasize the challenge and excitement of planning, training for contingencies, trauma research, operational medicine, CBR, cold weather medicine, infectious diseases, environmental medicine, aviation and space medicine, submarine medicine, etc. And what a fertile field for preventive dentistry—an opportunity unequaled in civilian life!

Assets and programs. What is the status of the assets of our Medical Department?

The Medical Corps has experienced a significant shortfall. The all-volunteer concept has not lived up to

the promises of its optimistic supporters, and we are almost 200 physicians short of our allowable end-strength. That is less than half the shortfall predicted but a year ago, and represents about 5%, not 10%, of the authorized end-strength.

The real problem lies in the specialty mix. While enjoying our needed numbers in some areas, we are pitifully shy of them in some others, such as orthopedics, OB-GYN, radiology, and flight surgery. These shortages are being addressed through a number of avenues:

- FAC "U" coding has enabled us to maximize utilization and still keep many operational billets, notably with the Marines, covered.
- The "Adak Plan" has enabled us to see that quality coverage is shared with remote areas, and even aircraft carriers, where the need exists but utilization is limited.
- Some vertical cuts, such as a series of OB-GYN services where CHAMPUS was available, have had to be instituted.
- The expansion of the family practice module and panel to the aviation community has been a move of incalculable mutual benefit.
- Recognition of the emergency service physician, and training and recruiting of these specialists, will release other assets to their primary field of specialization.
- The quality of our recruits has markedly improved over the past 12 months, and the scholarship program has been fully subscribed. When in a few short years the output of that program is combined with our share of the graduates of the Uniformed Services University, our numbers problem will be solved.

The Nurse Corps has increased its retention percentage to 60%. Recruiting programs have been developing a high yield of quality nurses, and a program is under way to justify an increase in the number of nurse billets —an increase I know is justified by the change in emphasis of care to more sophisticated nursing, use of nurses as practitioners, shift in patient loads to outpatient services, and augmented patient counseling and education.

For the first time in recent memory, the Dental Corps faces a potential shortfall. More emphasis must be placed on dental officer recruiting to erase the shortfall. These efforts will be closely watched. Should recruiting fail, restoration of the scholarship program will follow as a must.

Sophistication of the various aspects of health care administration has prompted potentially sweeping changes in career patterns for the Medical Service Corps. These advances require more training and education, and this need in turn is being met by the institution of three new course curricula at the Naval School of Health Care Administration: an advanced health policy and planning course, a patient services administration course, and a course in advanced finance and supply. These careers within a career are attracting talented, bright, and dedicated candidates whose futures are being ensured by patterns of advancement never before made available.

Additional pharmacists have been recruited, and we are in the process of recruiting audiologists. In the very near future, social service workers will be recruited into the Medical Service Corps.

The health care administration field is now so complicated that the time has arrived for specialization. A plan has been drafted to permit specialty fields of finance, information management, supply, and patient affairs, in addition to general administration. These will allow for career progression and promotion while remaining specialized. Our experienced finance officers will now remain where they are needed—in finance—and will still have a chance for 0-6.

The Hospital Corps is undergoing scrutiny to establish more equitable rotation, particularly of specialized staff. The revitalization of the Physician's Assistant Program, whose ranks will be filled by tapping the highly capable advanced hospital corpsmen, will go a long way to alleviate the impact of our shortages.

"One Navy" speaks not only to the earlier mentioned communities on the active-duty side but refers to the Reserves as well.

Too often and too long, the Reserves have been given patronizing lip service until the time of crisis, when they come to swell our ranks and lend their talents and their lives, if necessary, to assure the success of our mission. No more. These dedicated Reserves deserve more from us, and if and when that time of crisis recurs, we will need their trained and dedicated support again. They deserve to be shortchanged no longer. We can give them no less than our best—for that is what we require of them.

Environmental and industrial medical problems are increasing daily. They require more and more of our resources. Still, the shipyard commanders are not satisfied. And we have only scratched the surface of the

Many issues were studied.

levels from prior years must be achieved through careful analysis of requirements and full justification for a new program, or a change in an existing program—including a careful evaluation of any offsetting costs.

It is not enough any more merely to say "I need this or that" or "My workload keeps increasing." Changes must be documented at all levels.

The balanced-budget concept should force you to re-evaluate existing programs to assure yourself that the programs are not only necessary but are properly planned and properly executed, in terms of resources expended against workload.

In the preparation of any upcoming year's budget, the history of the resource execution for the year immediately past is of prime importance.

During the preparation of the budget, the Bureau makes commitments for certain actions—promises, of a sort, that our resource execution plan will fall into a given pattern. If, in the execution of your annual budget, you significantly deviate from the financial plan you submitted, which was approved, it would adversely affect our credibility with the Navy Comptroller and could possibly have the same effect on your credibility with the Bureau.

This is not to say that changes cannot or should not be made after budget execution has started, but the rationale must be apparent and justifiable to everyone concerned. Our collective credibility is of enormous importance in the acquisition of resources to carry on all Medical Department activities.

The system that requires you to report to the Bureau is also the one that allows the Bureau to report Bureau-level budget executions in a timely fashion to higher authorities. We are attempting to improve the management information system in the Medical Department, particularly through the application of data processing systems, so that we can reduce some of your report preparation burden. We are well aware that the reporting requirement is one of your biggest problems in terms of people and time—and, for some of you, even in terms of getting the reports to us after they are made.

The BUMED reporting requirements to higher authority are of such critical nature that the timeliness of our reporting, based on your report, frequently makes a great deal of difference in the competition with other major claimants over budget adjustments during the execution year.

I think I ought to pass along another little fact that may not be too well understood. The entire government watches us but, in addition to being interested in the amount of resources provided for our medical services,

our financial colleagues in the Navy and in DOD and OMB are equally interested in the rate of obligation of these resources. They not only watch how much we get but also want to know at what rate we spend it. If one looks at the DOD budget, one is immediately struck by the fact that the rate at which these monies are obligated has an enormous impact on the nation's economy.

Monitoring. Tracking the rate of obligation of resources is one of the mechanisms by which the performance of the government at large, and the Bureau in particular, is monitored. But there are other ways in which Medical Department resource execution is monitored. One such way is looking at the migration of funds between various expense categories. For example, if significant O&MN dollars migrate into the maintenance of real property in comparison with planned maintenance funding, this makes our plan suspect, especially if we have defended the need for O&MN dollars that migrated. Frequently, dollars migrate from maintenance projects to minor construction projects or minor equipment projects.

In many instances, as I suggested earlier, the Bureau may have made specific commitments to the Navy Comptroller to take reductions to comply with fiscal constraints. When the budget execution reports fail to show that we did what was promised (I would remind you that these promises were based on financial plans submitted from your activities), our collective financial credibility is at stake.

Some reports involve mistakes in the categories of expense assignments. For example, a year or so ago, the Navy Comptroller threatened to take away some of our travel dollars because they were incorrectly reported, giving the budget monitors a false impression.

It is important that communications between the field activities and the Bureau be effective, complete, and continuous. Problems always arise during the budget execution phase, but the earlier the problem is identified and quantified, the better we can assist your activity in solving it and preventing future difficulty. For example, if you perceive an increase in your laboratory workload, such information should be the basis for you to reevaluate your plans and notify the Bureau that you have such a problem. Similarly, any increase in specific costs, such as utilities or other externally controlled costs, should be recognized and reported as soon as possible. By so doing, you make the Bureau aware of the problem for the whole department, not only for your activity.

What I've said speaks to a future with greater controls and less flexibility. But, simply stated, we are being asked and directed to plan carefully, to make effective use of our resources, to execute them according to the financial plans, and then to report that we have done so. That's really just good management.

It's our job to manage well—it's never been less than that.

Issues in Medical Program Planning

VADM W.N. Small, USN
Director, Navy Program Planning

Thank you for inviting me today. Theoretically, I'm one of the few people in OPNAV who is not an advocate of any particular thing. My associates and I, in the Office of Program Planning, tend to be looked on as being for nothing and against everything, but really what we do is provide a check and balance, to make sure that our programs are validated and can be defended when the priorities are all put together.

With respect to the Medical Department and our tasks in the programming and budgeting cycle, the most important thing we must do is articulate, in a manner that we all understand, what the Navy's concept of health care really is.

Many people—the Secretary of the Navy, OSD, and even those of us in the line Navy—have very definite perceptions of their own as to what Navy health should be. Even though I've been educated by VADM Arentzen and others, I must conclude that I have not yet come to an understanding of the total complexity of this issue. I recognize that readiness for contingency operations is the number one mission of the Medical Department, as it is for those of us in the general line; but how that contingency mission is going to be executed, and what the state of training and readiness of people and equipment to carry it out should be, I frankly can't state in program terms. A great deal of effort has been made in the past year to provide a vehicle—a plan of action—that will explain to those outside your field exactly what that concept comprises, including the procedures by which contingency operations will be executed.

The use of the Naval Reserve, like all other aspects of this problem, is also a very hard issue to define. I'm not too sure—having just participated peripherally in "Nifty Nugget," the worldwide mobilization exercise we went through—that we really know what the capability of the Naval Reserve is, specifically to backfill the hospitals when the active-duty personnel deploy on contingency operations. That's a total-force issue, but it also has major financial implications in your effort to develop a coherent Navy program plan for the Medical Department.

Standards of quality often come up in my arena when we talk about budget requirements, and BUMED must learn to state its requirement in a form that has meaning other than dollars and cents. When we talk requirements in terms of dollars alone, it has very little meaning. What we need to know is: What does the program represent qualitatively? What is the impact of not having that program executed? We must establish a

baseline in terms of quality which will have credibility in defending budget increments in the medical area. In this context, we must define the relationship between professional medical personnel and lay personnel? What is a good ratio of physician's assistants or paramedics to the requirement for fully competent, board-certified specialists? What is the responsibility of the Medical Department for what I call social issues? We seem to have an increasing requirement for counselors and other people to handle not only the "abuse" kinds of problems, but also a rapidly burgeoning area of occupational safety and hazards.

An issue I often hear debated within my own shop concerns the orientation of medicine to operational fleet support or to the teaching hospital. I know VADM Arentzen has very strongly stated his direction that the primary orientation of Navy medicine should be to support the fleet. It's an interesting and important issue, because the regionalization of facilities and capitation budgeting seem to work counter to that—and that's a very parochial view of my own. I do think this trend, at least in the perception of the line officer, tends to diminish fleet support. From the budget standpoint, we're going to be pushed harder and harder to do more and more consolidating, and we must not fail to recognize, at the same time, the resulting impact on our own people.

A similarly large and emotional issue is CHAMPUS versus inside care for Navy beneficiaries. VADM Arentzen and all of the staff have been very active in trying to get the percentile payments for CHAMPUS up, to make that alternative a little more attractive to our folks. Again, this is an issue that has many protagonists, each with a different axe to grind. All I can say is that it is an area of very high visibility and great emotional impact, because of its long-term affects on morale, welfare and career retention within the Navy.

I'd like to emphasize what RADM Wilson has said this morning about the importance of the planning, programming, and budgeting system, because it is that train in the Navy which carries an annual allocation of dollars to the right places. It moves along at a relatively slow pace but, like Japanese trains, it stops for very short periods at highly specific times. The window for getting aboard is very short. If you don't have a validated program, if you can't state your requirement in the kind of language that the system understands, or if you can't interact effectively within your claimancy, you will miss your opportunity for the fiscal year.

I think one of the biggest legs up on getting this problem solved is VADM Arentzen's accession to the role of OP-093, which makes him a principal at the bargaining table, rather than a claimant working through some OPNAV sponsor, as he has in the past. He will now be able to compete directly for the dollars, and if he is able to defend his program, his ability to get the requisite support is dramatically increased. But again, if he is not backed up by good data and persuasive arguments, which you must provide, then the ability of others to reach into *his* pocket is also enhanced.

Finally in response to your final agenda item, I'd like to say: Have no fear about rapport and support from the general line. We look with great affection on the Bureau of Medicine and Surgery and on all the medical professionals associated with Navy health care. You have the support of everyone in our Navy in the continuing improvement in the quality of medical service and in providing those facilities which are essential to the environment in which you work. Please count on me and the OP-090 organization to help in any way possible; give us a call.

Medical Support for the Marines

LGEN Lawrence F. Snowden, USMC
Chief of Staff, U.S. Marine Corps

The fundamental issue that I have to take up with you at this time is medical care for our combat Marines. I focus my remarks on *combat* Marines because that is the focus the Commandant and all of us in Washington have toward our Corps.

You know, we say that the key to the Marine Corps' success is the young Marine with a rifle in his hand, who is commanded to go seize a piece of real estate, hold it, and—hopefully—survive. Now having charged him to do that, we certainly owe him the kind of support that says: If you are wounded in accomplishing your task, we are going to take care of you. We are going to ensure that you return to your unit quickly, if possible, and if that's not feasible, we're going to ensure that you get the best medical care possible, in order that you (1) survive as an individual, and (2) continue service as a Marine—and most of them want that.

I found out the other day, as I researched some statistics about veterans for a speech, that if you go back through all the wars since the birth of our nation, you find that 45 million Americans have become veterans through military service. Of those 45 million, 30 million are still alive—including some 295 veterans of the Spanish-American War who are still around, at an average age of 98.

The Veterans Administration will spend this year $5.8 billion in medical support of our living veterans—$1.8 billion more than the Marine Corps budget for 1979. That is a lot of money for veterans' care. And despite the fact that it is the general responsibility of the VA, I know that it still holds problems for you, because of the number of our retirees who are veterans but who still look to you, as the Navy support for the

Marine Corps, for help with their medical problems.

Now, I am sure that you wouldn't want to debate about whether this country might go to war any time soon over some "foolishness"—which is now given as the reason why we went to Vietnam. The fact is, in my role as a Marine general officer since 1968, I have been saying that I don't think the United States is going to go to war over a political question. The American citizens, I think, would not stand for that.

On the other hand, since 1968 I have been saying—and I am convinced of it—that the greatest potential for conflict in the future lies in the battle for resources that we don't have. We cannot survive as a nation with only the resources within our borders. You couldn't have even a telephone if you had to build it from the resources available within U.S. borders.

I am trying to make the point that the United States cannot live alone any more. The fact is that there is the potential, whether we like it or not, for competition over resources.

Combat readiness. Let's recognize that the Marines' position in all this is that we don't know what is going to happen out there, but we have got to be prepared to go wherever ordered, against whomever, whenever called—and do it quickly. Therefore, we have to maintain a high state of combat capability.

From the standpoint of the force-readiness position of the Marine Corps today, we are at the highest peacetime level ever, with our units ready to go to war—and do it instantly—and win.

Now, having said that, I will quote to you a portion of a letter from LGEN Les Brown, who retired as Fleet Marine Corps Pacific Commanding General on 1 October 1978. In his closing days, he wrote to the Commandant: "Mass casualty handling has cost me many hours of sleep. If there is an area where we have let the young Marine down, it might be here. I have pulled no punches in telling anyone who can help us about this problem. If there is one thing that could do irreparable damage to this Corps of ours, which claims to look after its own, it would be the loss of young Marine lives because we don't have the wherewithal to treat them. . . ."

I wrote a response for the Commandant to Les Brown, assured him of our concern, and assured him that we would continue to work on the problem. But I don't—as you don't—have an immediate answer to give him and make him feel exactly comfortable.

The primary message I want to discuss with you this morning is the importance of our working together to do two things. One is to remember, in all the problems that beset you in looking after the Marine and his dependents in garrison, that the important thing is to get your young medical officers into the field. In particular, get them acquainted with the Marine Corps through service to the Corps—service in the field—and let them recognize that their concerns for the Corps are not limited to the regional medical center approach. The fundamental task centers on that Marine in the field, and that somehow has to come first.

You've heard the old saw that it is very difficult to keep your eye on the mission of draining the swamp when you are up to your waistline in alligators. Well, the alligators that are snapping at you come from the Marine when he is in garrison—from the concerns he has over your treatment of his wife, your treatment of his child. That gets to be a particularly terrible problem for him (whether it is real or just perceived) when he is in the field, undergoing training, and is separated from them, and he gets a letter from home that says his child is not being adequately taken care of. Now maybe the mother just doesn't understand; maybe the child doesn't need what she thinks he needs. But that is a problem you and I have to deal with, if it is a perception in the mind of that Marine and his family.

But while I want every dependent and every wife and every child to be attended to in the way they'd like to be attended to, there is a more fundamental problem I want you to think about. The fundamental support that we have got to have for the Corps must center on that Marine in the field, who is going to fight when the chips are down. We must ensure that he can survive, if possible, and continue to be an asset to the Corps in that military action.

I know that you are concerned here with the management of resources, management of personnel, and OPNAV and Bureau relationships. I have no hope that I could add anything to your agenda that says: "Put aside some of those and center on how you are going to provide support to that Marine in the field." But it is a thread that I must ask you to weave through all of these topics.

While you are worrying about the resources at the regional medical center, remember that the Marines in the field don't get to the medical center. Oh, they get there eventually, of course, but initially they have to be treated in the field, where the accident potential is high in peacetime—from artillery shells that go wrong; bombs that drop in the wrong place; whatever. The potential for terrible kinds of accidents in the field is very high in a peacetime environment, when we are so intent on our training.

Operational experience. I suspect that some of you here have served with the Corps and were pleased about it. I will acknowledge that there may have been some who have served with the Corps and were not pleased about it. We don't expect everybody to like the Corps, but more do than don't, I am happy to say.

The point is that it is important for you, as the senior medical members of your community, to help us get the idea across to the younger members—your subordinates, the younger medical officers—that service with the Marine Corps is important to their career as officers in your Medical Corps. I would hope you can persuade them that service with the Marine Corps in a medical capacity is valuable professional education for them—

that it is a wonderful experience that can't be bought any other way—and that they should view it as a plus in their career pattern rather than as the result of irritating the medical detailer. If the latter is the attitude they have, they are never going to reach the kind of Marine Corps - Navy relationship that characterizes everything else about our Navy - Marine Corps team. And that team, believe me, is worth a great deal to both services.

There are those who have suggested in recent years that the Marine Corps' interest in Europe means that the Marine Corps is interested in pulling away from the Navy. I categorically deny that, and if you give me the name and phone number of anybody who makes the charge, I will be glad to talk to him. The fact is that there is no way the Marine Corps can proceed and survive in the years ahead if we are not a part of the Navy - Marine Corps relationship. That is fundamental to us, and we guard it jealously. But there is lots of room, within that spirit of cooperation and service that we render to each other, to be sure that down at the lowest levels of the Corps and the medical service, our men begin to work on these problems together.

I would hope you encourage your young officers to be eager to serve with the Fleet Marine Force. I know there are disappointments in serving at the battalion aid station, where they don't see a lot of triage but see runny noses, ear problems, sore throats, and bad feet. But while they are missing out on that part—and I know that is a concern to the medical officers who serve at the BAS level—they are at the same time coming as close as they can come in peacetime to knowing what kinds of problems will confront them when war comes.

The fact is that the old military guys are getting older, and we are losing a lot of great combat experience from both our services. We have a large number of Marine officers now moving up to the battalion staff level who have not, in fact, heard a shot fired in anger. Well, so what? The fellows who went to war in World War I, and many who went in World War II and became senior commanders very quickly, had not heard a shot fired in anger. They did well, didn't they? What's wrong with that?

Well, what's wrong is that a lot of the things they did, and that we have managed to stumble our way through, could have been done a lot better if we had worked harder at training in fundamentals in the field before those events occurred.

So that's what I'm asking you to do. Let's see what we can do to get your young men and mine together in the field, to do as much as they can do, in the absence of those shots being fired in anger, to know how to handle those casualties that come in by the truckload to that battalion aid station. That is where, instead of having the modern medical facilities that you would like to have to operate, you are operating in a tent. And you *will* be operating in a tent if we don't get better support through the budget for some of those nice medical components and shelters that we keep asking for, and asking, and asking.

Peacetime planning. Now, what are you going to be prepared to do if war comes and we are as "bad off" as we are now? And I think most of you agree that we are "bad off" in many ways—in materiel and in shortages of some people.

Well, that is another part of what we have to concentrate on in peacetime, because the primary function of those of us in the military establishment in peacetime is to plan for that terrible situation that exists as soon as the crisis comes. We have got to be prepared, with adequate peacetime planning, for the worst-case situation in war. We need the best kind of planning and cooperation—from the lowest levels, right up through all elements—so that you, at your Navy Surgeon General level, and we at the Marine Corps level can say, "These are our requirements, now that the chips are down; see how fast you can fill them." And those of you who have been around at the opening of a conflict know that when they finally take the constraints off the system, a lot of wonderful things can flow through the pipeline—and flow quickly.

I recognize your peacetime medical problems and medical care is important. But I hope there are ways that can be provided in addition to getting at what I think is most fundamental to our mission—and we Marines are mission oriented. Our primary mission, as I have said, centers on that young Marine who is out in the field with a rifle in his hand, or a machine gun on his back, or operating a mortar or an artillery piece. And we have got to be sure—as we look to resource management and all these problems that beset you at the regional medical center level and the Bureau level —that you keep in mind our mission orientation, which is to get out on the battlefield with that young man and win.

I seize the opportunity this morning to tell you that I am appreciative of the support I have personally enjoyed from the Medical Corps of the Navy over my years as a Marine. I look forward to working with you and to having your people work with us at every level of the Corps, to ensure that we face mutual problems with mutual cooperation, for the benefit of both services.

Medical Support and the Logistician

VADM T.J. Bigley, USN
Deputy Chief of Naval Operations (Logistics)

As you know, I am the Deputy Chief of Naval Operations for Logistics, and as such I enjoy a very close working relationship with the Surgeon General.

VADM Small

LGEN Snowden

VADM Bigley

Until the recent establishment of the new office of the Surgeon General on the OPNAV staff, OP-093, the DCNO for Logistics was responsible for day-to-day representation of medical issues at the OPNAV level. Even with the establishment of the Surgeon General's new office, my staff and I continue to maintain strong ties with the Bureau of Medicine and Surgery.

At the present time, there are several areas of concern in logistic support. We recently had a worldwide command exercise, known as "Nifty Nugget," that was an eye-opener to many people. It pointed out to all of us in the logistics field just exactly where our shortcomings and shortages are. At the same time, it did not leave us completely despondent about the future. But "Nifty Nugget" is going to be a term that we are all going to hear a lot about in the next few months—particularly as we approach the new POM process at the budget table—in relation to the supportability and sustainability of our forces.

When we think of logistics, we normally think of the traditional "three B's": beans, bullets, and black oil. But you, also, are concerned with logistic support—that is, support of the human being.

There are two programs that are currently on the front burner with us in OPNAV. The first is the fleet hospital. It has been recognized for some time that we do not have adequate fleet support for casualties, in the event of a worldwide conflict.

The second program—to provide an alternate to the hospital ship—has come to the fore because of the retirement of *Sanctuary*, the last of our hospital ships.

These two programs will have a pricetag of approximately $300 million.

The need for the fleet-hospital program was recognized in 1976. Under the able leadership of RADM Al Wilson, the Navy started devising a new form of fleet hospital that is basically a combination of containers and tents. There has been a callout in the CINCs Operational Plans for approximately 12 of these fleet hospitals. They are not cheap but they are certainly necessary, and they have been recognized as being a valid requirement.

When we get involved in the POM process for 1981, the fleet hospital concept is going to have to compete at the budget table. But we in the OP-04 organization strongly support it, and I am sure we will be able to make others realize that it is absolutely essential to get started on this program. Indeed, if we are successful, we can expect the first fleet hospital to be in inventory in FY 1982.

The second program—an alternate for the hospital ship—is a little more complicated and has not been clearly defined as yet. Initially, the concept of using containerships with containers, configured as hospitals, that could also be used ashore—sounds very attractive. However, there are problems of functional separation with the hospital container units on board a ship.

We have asked the commander of the Sea Systems Command to expedite his study and review of the problem. Hopefully, that study will be completed in the next few months, and this program, too, will take its place in the competition at the budget table.

One of the things we found out, in the Nifty Nugget exercise, is the shortfall in our advanced-base functional components, the ABFCs.

Fleet hospitals are part of the advanced-base functional components, which comprise groupings of materiel and equipment required for the performance

of specific tasks at advanced bases. In the fleet commander's or the CINC's OPlan, if he states that he is going to need an advanced base in some remote corner of the world, this is the equipment that is called out to provide support at that base. Fleet hospitals could well be the type of function the fleet commander wants at a particular advanced base.

In reviewing the fleet commander's plan, we found that what he had called out as his requirement far exceeds what is currently in the inventory. This is the problem: identifying the funds we need in order to be able to provide not only the fleet hospitals but also the other advanced-base functional components that will be required. However, I feel optimistic that—particularly as a result of the Nifty Nugget exercise, which has pointed out our shortfalls in combat sustainability—we will have a very sympathetic ear at the budget table.

When I think of my past experience in the Navy, primarily associated with the operating forces, I often wonder how I ended up being a logistician. Those of you in this room, who have been dealing for many years with support of our people, are also logisticians.

I recently came across a piece, author unknown, which describes the logistician, and which I thought might be of interest to you. It goes like this:

An ancient historian once wrote a very erudite exposé concerning the logistician and his place under the sun.

Logisticians are a sad, embittered race of men, very much in demand in war, who sink resentfully into obscurity in peace. They deal only with facts, but must work for men who traffic in theories. They emerge during war because war is very much fact. They disappear in peace because, during peace, war is mostly theory.

The people who deal and trade in theories, and who employ logisticians in war and ignore them in peace, are generals (or admirals). Logisticians hate generals. Generals are a happily blessed race who radiate confidence and power. They feed only on ambrosia and drink only nectar. In peace they stride along confidently and can invade a world simply by sweeping their hands grandly over a map. In war they must stride more slowly, because each general has a logistician riding on his back, and he knows that at any given moment the logistician may lean forward and whisper, "No, sir, you can't do that."

(I found myself in that position during the Nifty Nugget exercise.)

Romping along beside generals are strategists and tacticians. Logisticians despise strategists and tacticians. Strategists and tacticians do not know about logisticians until they grow up to be generals—which they usually do—although sometimes generals will discipline errant strategists and tacticians by telling them about logisticians. This sometimes gives strategists and tacticians nightmares, but deep down in their hearts they do not really believe the stories, especially if the general lets them have an occasional drink of his nectar.

Sometimes a logistician gets to be a general. In such a case, he must associate with generals, whom he hates. He has a retinue of strategists and tacticians, whom he despises, and on his back is the logistician, whom he fears. That is why logisticians who become generals are a fearsome and frustrated group who wish that they were anywhere else. They beat their wives, get ulcers, and cannot eat their ambrosia or drink their nectar.

I think that all of us in this room are logisticians, and we must be prepared to tell the tacticians and the strategists, who may not want to listen, what they cannot do.

Medical Care: The Beneficiaries' View

R.W. Nolan
National Executive Secretary
Fleet Reserve Association

As the National Executive Secretary of the Fleet Reserve Association, I'm privileged to represent 142,583 shipmates and their families of the Navy, Marine Corps, and Coast Guard. Of these people, about 30% are serving on active duty. The remaining 70% are either serving in the Fleet Reserve or fully retired from active military service.

I'd like to stress to you that the views I present to you today are not just my views—they're not just based on mail I get across my desk.

A year and a half ago, the Fleet Reserve Association, in answer to the President's Commission on Military Compensation, formed its own compensation study group: the White Hats' Pay Panel. The panel went out into the field in seven areas across the nation and held public hearings, asking active-duty people to tell us their views.

Also, we have the Navy retirees' seminar program, held primarily in October each year. Under this program, the various military commands hold seminars for retirees, to inform them and discuss some of their problems.

I have been privileged to attend 60 of these retirees' seminars around the country. So that experience, the experience we had with the White Hats' Pay Panel, and my own job of trying to keep in touch with what people are thinking—all these form the basis of what I'm going to say about how the military community views military medical care.

The military community—both active-duty and retired—views its health care as a rapidly fading benefit. Military personnel have always considered the military as their "family doctor," but in the last couple of years, for various reasons, their family doctor has been becoming a nonentity. The care they were led to believe they were going to receive is starting to disintegrate,

and very rapidly. They are bewildered by a barrage of conflicting actions from various sources; they can't really figure out whose responsibility it is to make sure they get that care.

Let me cite a few of the conflicting things that are happening. Congressional committees (primarily the Armed Services Committee) say: "Yes, you are guaranteed care. Of course it's on a space-available basis, but we're going to ensure that you get that care. Just don't let it cost too much because then, you know, the Appropriations Committee gets unhappy."

Then the military community sees the Appropriations Committee take a meat axe to the budget for medical care and for CHAMPUS. They hear that the Department of Health, Education and Welfare is trying to elbow its way into military medicine. They wonder why the Administrations—both Republican and Democratic —have placed far more emphasis on hardware than on people.

Of course, they are totally fed up with the red tape and bureaucracy of CHAMPUS. And it did not help too much when the Secretary of the Navy testified publicly that CHAMPUS is "a total disaster."

Finally, they are really bewildered when they hear: "There's going to be a new study made. Everything's going to be all right. We're going to take a good look at this—we're going to analyze the situation."

Very frankly, they greet that with derision. They're sick of studies.

The vast majority are disenchanted with the delivery of care at military medical facilities. They appreciate that there's a doctor shortage, but they're fed up with long waits for care and with the unprofessional appearance and attitude of some medical personnel. This, in a nutshell, is what I believe is their view of medical care today.

Now, keep in mind that I'm a beneficiary of health care too. My FRA members are beneficiaries of health care, and they don't like to admit it but maybe they're a little bit of the problem. So let's address these problems and think about some of the things we might be able to do.

The very first thing, I believe, is that both the providers and the recipients of care must stop resigning themselves to the "hopelessness" of the situation. It's not a hopeless case—things can be done about it.

Next, I think we should address ourselves to what we can do in-house to improve the situation within the military health care delivery system. The basis for such action should be a rational assessment of exactly what's going on. We should be a little frank on both sides of the street; acknowledge what can be done effectively; then set about to do the things we're sure we can do, in a positive manner.

Establishing communication. Commanding officers of the military medical facilities, in particular, should start establishing a viable communication link with the military community. Plans on paper don't work. Plans entered into and handed off to somebody as a collateral duty don't work. You've got to get involved in the project, sink your teeth into it, get a grip, and make sure that you tell your side of the story.

Be ahead of the game. Have that community out there knowing that you are making good use of your resources and understanding why you are changing a policy or establishing a new one.

Make your channels of communication work for you. Wherever you have military medical facilities, you've got branches of the Fleet Reserve Association, the Navy Wives' Club, etc. Bring those people on board. Don't just wait until they have some special function and then send somebody over to speak to them. Have somebody that's knowledgeable go over to a meeting (it doesn't have to be the admiral; it doesn't have to be the CO of the hospital) and not say anything—just meet the members and get their thoughts. Then the next time, when he does get up on the platform, he will be welcomed as a part of the community and listened to a little better.

The Fleet Reserve Association has an in-house publicity organ, as well as a national magazine. We print it ourselves, and it goes to every branch president, every branch secretary, and every branch membership chairman, plus other people that each branch designates according to its size—maybe a total of 2,500 people. We have another mailing list that totals about 3,300 and includes every command, every command master chief petty officer in the Navy, every command career counselor in the Navy, the command enlisted advisors of the Coast Guard, and the command sergeant majors of the Marine Corps. So we can offer you a beautiful opportunity to get the word out to these people. We have our own in-house printing; we have a multilith press; we cut stencils; and anything that can be photographed we can print—we can back you up.

I'll tell you very frankly that, from where I sit, it's the rumors, the half-truths, the misunderstandings that are killing us. If you get two-way communications going, you're going to save yourselves an awful lot of grief.

Well, you say, that's going to take a lot of work. That's true, but it's going to take a lot more work to get things untangled if we keep on going the way we are now.

I can appreciate, very sincerely, the problem that you have with the shortage of doctors, staff, etc. I think VADM Arentzen can say—as probably others of you might—that when I have testified before Congress on these issues I have always come to the Surgeon General's office first and gotten that side of the story. In fact, the largest share of our success as an organization has been gained because the Navy, the Marine Corps, and the Coast Guard cooperate with us and give us good information on which to base our assessments.

With this information we can assist you in many, many ways—on Capitol Hill, in the Pentagon, in the military establishment, and in the military community.

We can educate the beneficiaries of the health care system in the ways we must use the resources we have at hand, and we can explain to them the things that are going to have to change.

One example is the case of the physician's assistants and extenders of care. It doesn't give our active-duty or retired personnel much of a problem to have a physician's assistant help us. (I served on a destroyer where we had a corpsman second class, and we were doggone happy to have him. We had complete faith in him—nobody ever questioned it.) But maybe our dependents are not going to have that kind of faith. So we need to get that across to them, and to explain that we've got to make the best use of our resources.

I sincerely believe it is going to be a long, long time —by that I mean a few years—before the Administration and the Congress get fully educated on health care as we would like to see it. But you can rest assured that the Fleet Reserve Association is going to do its very best to make that happen as soon as possible, including drawing on your expertise to help.

Meanwhile, we're going to have to improve things in-house. The services individually—the Navy, the Marine Corps, the Army, and the Air Force—are going to have to get their acts together, so that the people on the Hill don't divide and conquer.

You must also remember that a national health care program is right on the horizon. It's going to be a while, because it's going to be expensive as the devil, as we all know. But nevertheless it's there. And I believe you will agree with me that if and when that happens, the military community is going to lose the broad range of benefits under CHAMPUS. I can't envision the U.S. Government adopting a national health care program and operating it over here while running CHAMPUS over there for the military.

Very frankly, from a selfish standpoint I don't think any of our members of the FRA are looking forward to a national health care program. But if we can get our acts together, I think that we can make our case much more forcefully to prevent a loss of benefits.

Only in this manner can we reach the ultimate goal of returning to the concept where the military is truly the military community's family doctor.

Learning to Communicate

RADM D.M. Cooney, USN
Chief of Information

I think we have a communications problem on our hands. You've all gotten chewed out a little bit by Bob Nolan. It was a friendly chewing out, but I think the message there is that doctors these days really have got to be dedicated medical professionals.

About five years ago, everyone was running around being "involved." They had to be "involved" with one another; they had to be "involved" with their jobs; they had to be "involved" with their associations. And now the Chief of Information comes along and tells doctors, dentists, and other medical professionals that they have to be "dedicated."

What's the difference between "involved" and "dedicated"?

Well, I just ask you to reflect on breakfast. We had ham and eggs. The lesson is there: the hen was involved, but the pig was dedicated.

I'm not asking you to lie down in front of the butcher and get sliced up. But I am saying that we are dealing in an environment that is difficult for us all. It would be very easy for you, as medical professionals, to say: "Gosh, everybody criticizes me. I am being singled out for attack. Yet no one is coming around with a list of names of new doctors or new nurses, or a large blank check for the money to construct new medical facilities or buy equipment and drugs."

You might feel a little bit like the Lone Ranger as a result of these messages being communicated to you. *Don't.* The entire Navy, and indeed most of the major institutions that comprise American society today, are being targeted with exactly the same type of skeptical evaluation.

While being aware of the fact that you are not alone in this pursuit of your faults doesn't necessarily make you feel as appreciated as you might, and doesn't suggest any immediate solutions to your problems, I think that it can help you keep the whole issue in balance so that you don't say to yourselves—either consciously or unconsciously—"Everything I do is wrong, so I guess I won't do anything." That could very well be a normal human reaction to what you could perceive as a lot of unfair criticism aimed directly and specifically at you.

Now it is true that criticism of Navy medical care tends to be intense because the people who are seeking it don't feel well for one reason or another. You know that a lot better than I. But let's put it into perspective.

Our nation began as a small unit of society: the pilgrim village, the pioneer town. All our associations were centered around the home, the church, and the immediate community—where common interests were well established and well known, and interpersonal communication was easy. It was all conducted on a face-to-face basis.

But this isn't the 1600s any more. Trace the development of that simple pilgrim society through the 1600s, the 1700s, the 1800s, the 1900s, and we see that everything has gotten bigger, and all the aspects of our society have gotten more complex as they have grown.

It is no longer possible to deal with the gut issues that hold our society together on a town-meeting, face-to-face basis. So we have created social organisms to take care of many of the problems which we used to deal with ourselves. We call those social organisms "institu-

Eleven workshops at the conference tackled assigned topics to develop policy recommendations.

tions." We have financial institutions, educational institutions, medical institutions; we have social institutions, welfare institutions, governmental institutions.

What is the public attitude toward institutions? It is what I have described to you: overcritical skepticism. We see that the institutions people are most skeptical about are the largest. And the largest of the institutions in the country is the government. The Watergate incidents accelerated that attitude of critical skepticism toward government—let's face it. People started looking around and saying: "Can we believe the White House? Can we believe the Congress? How did we get into this situation?"

And within government—next to HEW, with which you are somewhat involved—who has the biggest chunk of dollars to spend, and who has the largest payroll? The Department of Defense. And within the Department of Defense, whose budget is the largest? Who is the largest employer of people, and who has the most difficult mission to explain? The Navy Department.

So we, wearing the blue and gold, find ourselves members of the institution to which perhaps the largest amount of dollar-oriented, social-oriented skepticism is currently being addressed by our society.

You, as doctors within the society, have your own special problems, because that skepticism comes not only from the outside but from the inside as well. And at the same time that this attitude is being generated toward us as naval officers, it is being generated toward you and your civilian counterparts because the institution of mass medicine is also open to the same broad general attitude of skepticism on the part of the public as a whole. So you are two-time losers, and you haven't even started the race yet. Congratulations!

You say, "Hey, he told me that I've got a problem and everybody else has a problem—I guess there's no solution."

That's not true. There is a solution.

'Image' vs. 'reputation.' Now, I'm going to talk to you about some basic rules of communication. The first thing that we have to be aware of, if we are going to be effective in communicating, is that there is a difference between "reputation" and "image."

We hear a lot of people talking about "image." The politician wants a "good image." You think you want a "good image" for your hospital.

What's the "image" of a hospital? I can create an "image" of Bethesda by showing a slide on a screen. An image is something that is artificial and created. You don't really care about images. You're not in the "image" business.

Let me give you a better illustration of that. I see this fine handsome young doctor sitting here—do you think we could turn him into a sex symbol? I think I could. If I had $100,000 to spend, I would rent him a nice Rolls Royce, buy him a sharp set of threads, subsidize him to be seen around town with the right female jet setters, and finally get him a date with a major sex symbol. So finally, on that Saturday night, his *image* too would be that of a sex symbol. But what would his *reputation* be

on Sunday morning? We'd really have to ask this super star because reputations are based on demonstrated performance.

I don't want you to think in terms of "image," because that will make you paint buildings that are cracked, have corpsmen shining shoes when they should be going to school, and doing a lot of other things to put up appearances.

My basic philosophy on this is that an institution's reputation will never be as good as its performance. In other words, we are always going to lag behind. But the difference between our reputation and our performance is an effective measure of our communications program, because *we not only have to do things well, but we have to tell people that we're doing them well.*

The other rule I want to throw at you is that *communicating without planning may let you stay even, but it will never help you win.* If you sit around and wait until the patient dies in the waiting room to figure out how you are going to explain it, you may get out of it all right, but you will not have the advantage of being able to explain to someone how—if you'd had the proper equipment or proper whatever—the patient might be alive today.

That is an extreme example, and I probably should have used a lighter one. But my point is the same one you heard from the preceding speaker, Bob Nolan: You're not telling people the things they need to know in order to be good patients. I'm sure other people have told you the same thing, either face-to-face or indirectly, or we wouldn't be having this conversation now.

What you must do is say, "I've got to have my reputation solidly backed by an effective communications program—based on planning—so that my staff, my patients, and my potential patients in the community will know, *really*, who I am, what I do, what my capabilities are, and what my capabilities are not—and why."

The message and the medium. That brings us to the first step of the communications equation: You have to figure out what it is you want to tell people.

The next question to ask yourself is, Who is it that you want to tell?

After you figure out what your message is and who your audience is, you must then decide what medium of communication is the most effective way to get this message to that audience.

Let's very quickly analyze the audiences. Who are they? They are: the active duty officers and enlisted personnel within your general area of responsibility, and their dependents; the retired personnel in your area and their dependents; and that very, very important special audience—the people who work for you, and their dependents. For all of them, you may have the same basic message, somewhat modified to accommodate their own unique, special interests.

So, in communicating, you are:

- defining the message;
- identifying the audience;
- modifying the message;
- figuring out the best medium to get it to the audience;
- transmitting the message via the preferred medium; and
- measuring to ensure receipt of the message.

Anybody will tell you that the most effective way to communicate is face-to-face. Get people in, talk to them, and answer their questions. But if you are dealing with an audience of several thousand people, as most of you are, that isn't very cost effective. So you have to fall back on the mass media of communication, through which you talk to thousands of people at the same time. And here you've got options.

You've got the print media—your hospital newspaper, the Plan of the Day, the bulletin board, special pamphlets—anything you think is needed to address the issue.

You've got the electronic media. If you're overseas, you can use Armed Forces Radio and Television. If you don't have that, it is possible to use tape recorders for both sound and video.

Finally, you have face-to-face communication in which you may not be personally involved, but in which members of your staff represent your command and the Navy.

Feedback. We also need to talk a little bit about what Bob Nolan mentioned earlier: feedback. You must maintain a *two-way* communications system, because you may be transmitting blue and the audience may be receiving green.

The only way you can know whether or not your message is being received in the way you designed it is to figure out a way to ask people. Put questionnaires in your hospital newspaper. Assign the Master Chief the responsibility of finding out what the perceptions of your own people are on certain issues. Check with a career counselor and see what people on your staff are telling him about why they are or are not reenlisting. Put a suggestion box near the door of the hospital or the dispensary, and leave some blanks and a pencil so that people will have something to write on while they are thinking. If you have the opportunity, have a Captain's Call on a regular basis.

Tools. CHINFO can provide you with a whole variety of materials, including Captain's Call kits and softwear in both radio and television for use overseas with AFRTS. There is the Newspaper Editors' Service, which goes to the editor of your hospital newspaper and carries information on current Navy policies and programs. There is *All Hands.* There is *Direction* magazine, which is addressed to your public affairs officer—and to you, because communication is a command responsibility—to tell you better ways to communicate. (There is a special supplement volume of *Direction* which combines past issues on community relations, internal relations, media relations, and family com-

R. Nolan

RADM Cooney

RADM McDowell

munication. If you haven't seen it, take a look at it; it will give you some ideas about how to proceed.)

Let's go through the communications equation again. First, you define your message: What is it you want people to know? Then you identify your audience: Who is it that you want to know it? You modify your message for the particular audience you want to reach; then you transmit the message via that medium; and finally measure to find out whether or not people have heard what you said, and whether they understand it the way you want them to. Then you modify the message and its transmission, and go through the same cycle all over again.

I'll give you a basic hint that any advertiser will verify. When you come to the point where you are so sick and tired of hearing your message that you don't think you can possibly say it one more time, your listener is *beginning* to perceive—just beginning.

Remember, this audience with whom you are trying to communicate—with whom you are attempting to establish a reputation through sound programs of information transfer, in a process called "communication"—has several thousand other messages a day being aimed at it, many of them from people more skillful in the communications process than you are. The listener must, in some way, audit all those messages, sort through them, establish priorities, and then take action. And he is not going to do that unless what you have done is planned and properly executed.

The public affairs officer. I do not expect you, as busy as you are and as highly trained as you are in your various specialties, to spend all your time in the communications business. It's time you got yourselves some public affairs officers—people who are trained in this and who can provide assistance, support, and direction; people who can represent you in various meetings and seminars and give you the feedback you need in order to carry out your programs.

Now, I can't give you a public affairs officer—the number of professional PAOs in the Navy is limited to 185. But that doesn't mean you cannot have an officer on your staff, selected because he has an interest in this, who can be sent to the Defense Information School; who can receive basic training in communications skills; and who can then polish up those communications skills by working with a professional public affairs officer stationed in the area where you are located.

The 'crisis' situation. Up until now, the program I have been talking about is what I would call a "continuing developmental program"—something you have to do on a regular, day-to-day basis, both internally and externally. But in addition to that, we all face that unusual circumstance where there is fire or disaster: something that brings national attention to an issue, such as we had at Oak Knoll and New Orleans. What do you do there?

You certainly don't turn to a lieutenant junior grade Medical Service Corps officer who got out of DINFOS last Thursday. That's what my office is for.

I am ready to provide you with help, support, and guidance on relatively short notice. You let me know what the problem is, and I will try to sort out the kind of help I think you need and tell you where you can get it.

I have regional offices in Boston, New York, Chicago, Los Angeles, Dallas, and Atlanta. They are manned by skilled professional information officers who can come to you, work with you, and provide you with support

and assistance for that particular problem.

They can't come there and run your day-to-day information program for you. But if you become the target of the national media and "60 Minutes" wants to see you, you will be informed by my office as to whether or not these people can come, and whether or not your participation has been approved by the Department of Defense. If the answer to those two questions is yes, then the team from the national network will be escorted by an officer from my office in New York or my office in Los Angeles, depending on where the network team is coming from. We will then provide you with guidance, assistance, and support, and will try to work with you to help frame the direction that the coverage on that particular show might take.

So I'm not merely saying, "Hey, you guys have a problem," and then walking away from you. But I do want to separate the two issues—one that we would call the "front page news issue" and the other, that of continuing, day-to-day programs.

If I can ever help you, please call on me. That's what we're here for.

Medicine and the Law

RADM C.E. McDowell, JAGC, USN
Judge Advocate General

I have come here today with the intention of giving you something more than the traditional lawyer's speech on the problem of medical malpractice suits.

For example, the typical address on malpractice would have me telling you that the number of cases has risen by 20%; that the figures involve many millions of dollars; and that the largest single recovery involved a man who had had both his lower extremities amputated erroneously and won millions, even though he didn't have a leg to stand on.

Instead of that kind of speech, I am determined to speak today on a wider subject: the entire field that may be referred to as "medicine and the law." I hope to give an overview of the interrelationship of our two professions, and to provide you with an appreciation of the many opportunities Navy doctors and Navy lawyers have to work together toward a common goal—for our professions do have many common interests.

Medical negligence cases are only one area in which Navy Medical Department personnel may have contact with lawyers and the legal system. Other areas include forensic science (the field of endeavor in which scientific principles are used to provide evidence in civil and criminal cases); preventive medicine, which to some extent attempts to avoid contact with courts and lawyers; mental health programs; child and spouse abuse programs; organ transplant programs; and others.

The fact is that ours is a society of law, and no significant endeavor of modern life can be accomplished without being affected in some way by the legal system. Medicine is no exception. Every patient presents certain potential legal problems to the health care system. Handling these problems, or preventing them before they arise, should be a part of total patient care. Let me give you a few examples.

On a daily basis, in intensive care units throughout the Navy, patients approach death in a comatose state. As this happens, the issue of brain death often arises. Those half dozen or so medical centers lucky enough to have a Navy judge advocate attached are able to consult with their attorneys concerning their state's definition of "death" and can summon the attorney for bedside legal consultation.

Similarly, if a patient is awake and alert, a will may be desired, and the medical staff may serve as witnesses of mental capacity when the lawyer prepares the document.

If no judge advocate is assigned to your facility, these functions may require coordination from the nearest Navy Legal Service Office by telephone. But the point is that, through the combined efforts of the Medical and Legal Departments, total patient care is achieved.

Medicine and law interact in the emergency room of your medical facility. For example, assault victim cases should be reported to local authorities for investigation, and rape victims should be seen by trained personnel skilled in ministering to their needs and preventing further psychic trauma.

I know that VADM Arentzen and the entire Navy Medical Department are extremely interested, as we in the JAG Corps are, in a program of care and comfort for the rape victim. A reporting and prevention program is available in Navy hospitals and in most civilian communities to deal with cases of suspected child abuse.

Physicians and lawyers alike have a duty to report all these types of cases to appropriate officials and to cooperate with local authorities as the legal case progresses. Again, total patient care is achieved when medicine and law interact.

Medicine and law interact also in the forensic context. For example, dentists play an extremely important role in providing records and performing examinations to identify unknown human remains. This type of practice may rarely be encountered in the Navy, but it is important that we all be aware of the potential need to help—in such times as natural disasters, airplane crashes, and the like—to identify remains that are unrecognizable from outward appearances.

Likewise, routine tests run for medical treatment purposes may play an important role in a forensic con-

text. Reports of blood screens or blood alcohol levels have obvious value in criminal or civil litigation, and physicians and technicians may be called to testify, to explain how those studies were performed and what the results may mean.

Finally, coroners and medical examiners play an important role in the forensic context. Medical personnel in the clinical studies should be aware of the need and opportunity for cooperating with these officials.

A very "hot" area that involves interaction of law and medicine is the subject of asbestos and its related health problems. I know there aren't many of you who haven't already heard of HEW Secretary Califano's announcement of a very serious situation involving the health of many Americans: the problem of disease related to exposure to asbestos. You know as well as I do that this exposure may contribute significantly to various respiratory diseases, including carcinoma and others, and that the exposure may occur as much as 30 years before the disease manifests itself. This has become a potential medical and legal nightmare, and preventive medicine people and others are taking strong measures to ensure that unnecessary exposure to asbestos is eliminated. Here again, the law and medicine work hand in hand.

I hope these examples of your profession and mine working together toward a common end will help you to foster an awareness, throughout Navy medicine, of the significant contribution we can make to each other's mission. Recognizing this potential for cooperation and mutual assistance is the first step toward real communication between us.

Malpractice. Earlier, I told you that I wasn't going to give the traditional lawyer's talk on malpractice; I wanted to talk about something more. Well, as you might suspect, I can't entirely resist the urge to mention medical malpractice. I want to give you a brief update on the problem, as we see it from the defense standpoint.

Last year my predecessor, RADM Dusty Miller, cited to a similar gathering some statistics on the total number and dollar amount of malpractice claims in the Navy. I regret to report that, as you may have suspected, the figures are even larger this year. We currently have about 175 administrative claims and 125 law suits involving allegations of a medical nature—medical malpractice. The total amount claimed approaches $400 million.

(Incidentally, this does not include the asbestos claims. Believe me, that total goes up every day, and is currently over $2 billion. But I mention this only as an aside. These asbestos claims and suits are not really a medical malpractice problem, and on the legal side we do not believe that we are liable for these claims anyway.)

The two largest claims settled recently involved the death of young mothers. Each left a husband and two children. One case involved the mother's death, immediately after she gave birth to the second child, and was settled for $120,000. The other involved treatment for kidney disease and was settled for $350,000. In both cases, negligence was rather clear.

Another case pending in the office may soon be settled for figures between half a million and a million dollars, by setting up a trust for the use of a severely brain-damaged child who suffered fetal anoxia during childbirth. Again, negligence is clear.

I don't mean to indicate from these examples that my claims attorney assumes negligence in every case. We find that about 25% of the claims we see have some substantial merit to them. These cases are almost always settled. Another 25% of the claims we see are clearly without any merit whatsoever and are quickly denied.

That leaves about half the cases, where expert opinions can be found to support either position. In these cases, reasonable small settlements are often attempted, in order to avoid the possibility of an extremely large verdict at trial. These settlements are always made without any admission of fault on the part of the United States or any individual doctor, and they should not be taken as such.

I want to point out that even though two of the three examples I gave a minute ago involved obstetrics, I do not mean to imply at all that obstetricians are less competent or more negligent than other specialists. We find that our cases involve pediatrics, surgery, internal medicine, and OB-GYN about equally. The prominence of OB-GYN cases probably results from the fact that this specialty sees dependents almost exclusively, whereas the other departments treat active-duty personnel who are barred from recovering from the government.

I also want to avoid giving the impression that the specialties I have named are the exclusive focus of malpractice cases. They are not. We have had radiology cases, pathology cases, lab cases involving mismatched blood, and general medical officers' cases.

Nonphysicians have also been involved. There have been nursing cases (mainly for medication errors) and physician's assistant cases (generally for misdiagnosis in the emergency room or misdiagnosis of some serious condition that masquerades as a simple malady). And there has been at least one dental case for extraction of the wrong teeth.

There have been a few cases involving the use of nonclinicians in the emergency room. Because I know this is a hot issue, I must add that the number of such cases is surprisingly small compared with the amount of debate the issue has received. I imagine a major reason for this is that nonclinicians are constantly aware of their limitations and are eager to consult with a specialist when they feel they should. Perhaps there is a lesson to be learned there.

The bottom line on all this is that there is no group of doctors, civilian or Navy, that is immune from allega-

tions of medical negligence. If all this is somewhat depressing, there is some good news to report. For any here who might not have heard, it can now be said that while no group is immune from being the subject of some claim of negligent care, every Navy doctor, every nurse—and, in fact, every health care provider in DOD—is immune from personal liability. This is the result of passage of the so-called Gonzales Act, through which Congress has provided absolute immunity to DOD health care personnel acting within the scope of their employment.

If any Navy doctor, nurse, dentist, or health care professional becomes a defendant in a case alleging professional negligence arising out of performance of his or her Navy duties, the U.S. Department of Justice will defend him or her, and the United States will pay for any judgment that might be rendered. All these people need do is get in touch with the closest Navy judge advocate, and we will take it from there.

An ounce of prevention. I wish to close with some thoughts on what you medical people would call the "pathogenesis" of the malpractice problem and some "prophylaxis" we lawyers recommend.

It is often said, in medical circles, that lawyers are the cause of the so-called malpractice crisis. In my view, the first cause of the malpractice problem is not lawyers; it is bad public relations and bad rapport with patients.

The second cause of the malpractice problem is likewise not lawyers. It is substandard medical care, which unfortunately does exist to a small degree.

The third cause of the malpractice problem, I must admit, is lawyers who know a good thing when they see one.

(Incidentally, I want to point out that claims of *legal* malpractice, both in and out of the Navy, are on the upswing. You are not alone. But we have no immunity from personal liability as you do.)

Given this pathogenesis of the problem, here are our prophylactic measures, based on our experience in defending thousands of cases over the years:

• *Keep good medical records.* In most cases, the medical record is the witness for the defense. If a case goes to trial, the physician usually cannot remember what happened and has to rely on the record to reconstruct events in the patient's treatment. If the record is

Plenty of coffee and a sense of humor helped.

incomplete or ambiguous, it only lends credence to the plaintiff's story, and you can bet that the plaintiff will have a version of the case that suits his own viewpoint.

• *Don't make admissions in the record or criticize others.* We have had one record, for example, in which a doctor wrote: "This patient is justifiably upset that the diagnosis was so missed in the Eye Clinic . . ." It later turned out that the physician who made that entry did not know the patient's entire history and admitted that had he known it, he would not have made the entry. We had experts who swore up and down that the care in the Eye Clinic was proper, and that the diagnosis could not have been made at that time. But with the confession of guilt in the record, the judge gave a verdict in favor of the patient.

• *Maintain good rapport with the patient.* This reminds me of the old law professor who complained that modern law schools teach a lot about the law but don't teach people how to "lawyer." I suspect the same may be true in med school: one learns a lot of medicine but not enough about how to "doctor"—the art of handling patients.

It is not enough to say "maintain better rapport," and I do not know how to teach that subtle art, but I do know that lack of good rapport—the feeling on the part of the patient that the doctor is too busy to level with him or that the system is too big to be personal—is a major factor in the filing of a lot of frivolous claims. That is why I listed "rapport" as the number one item on my list of pathogenic factors. Furthermore, a large number of claims that would otherwise have been filed are averted because good rapport was present throughout, and the patient harbored no ill will toward the physician or the system.

If I could emphasize one aspect of physician training above all others, it would be this establishment of good rapport with patients. I challenge every hospital CO to instill this thinking in his young doctors.

• *Consult.* Too many times we see claims in which a choice of treatment was made without proper consultation with specialists in the field. Particularly given the regional medical center concept, there is no valid response to the lawyer's question: "Why didn't you consult with a specialist, doctor?"

• *Keep your patients informed.* There is a natural human curiosity about things medical, particularly when they relate to one's own body. Patients have a right to know what you plan to do to them. Keep them informed every step along the way, and perhaps they will be more forgiving if less-than-perfect results occur.

In summary, let me say it is my opinion that Navy medicine is doing an excellent job. Even considering the rise in the number of claims, I believe that your patients receive high-quality medical care, comparable to that found in the civilian community. Given the manpower and budgetary constraints placed upon you, I have a hard time figuring out how you do as well as you do.

Operational Planning

CAPT J.J. Quinn, MC, USN
BUMED Deputy Director of
Program Planning and Analysis

I intend to give a brief discussion of operational planning and our recent experience in the "Nifty Nugget" exercise.

It is my opinion that the very survival of the Navy Medical Department, its proud tradition of service to our fighting men, and its illustrious history of "can do" is in dire jeopardy. The Navy Medical Department as a whole seems to have little, if any, grasp of what support to the operating forces means. I would imagine each of you has your own concept of exactly what that means, and each concept is probably different.

Let me briefly define our concept of support for you. We exist for only one purpose—to go to war on a moment's notice. Any health care system in this country can do what we do in peacetime. The DOD health care system, however—and specifically the Navy Medical Department—exists to sustain our fighting forces at sea and in the field, and we must move rapidly when the call comes for service to the fleet and the FMF. No other health care system can or will do that. Kaiser-Permanente does not deploy.

In large measure, the combat sustainability of our naval forces depends on our readiness to deploy with them and to return to duty as many personnel as possible. We must do our thing in theater; if the wounded are sent home, we probably can't get them back. There is not sufficient lift capability in airplanes and ships, and there are no replacements in manpower. Of course, those unable to mend quickly will be sent home.

Our mission, then, is clear. It is the conservation of manpower. Inherent in that mission is the restoration of functional health, the return to duty of as many as possible, and the minimizing of disability.

To accomplish those objectives, we must be capable of rapid response, mobility, and flexibility. To achieve our objectives, to support the operating forces, a smooth transition from a peacetime to a wartime configuration is required.

The Medical Department is divided into three major systems, each contributing to our wartime mission. Briefly, these systems are the CONUS health care resource base (the medical and dental centers); the overseas nontheater medical support system; and the theater of operations, or the operating forces.

As our guide for war planning, we have the Secretary of Defense's Consolidated Guidance, which states quite categorically that "we will size the peacetime Medical Department according to wartime needs, utilizing the total force concept"—that is, the active force, the Reserves, and the civilian resource base.

Gentlemen, this is not a game. We have recently

completed a major exercise, testing whether our system can accomplish its mobilization mission or whether our naval forces, sailors and Marines, must go into war without us. I'm afraid that, if this exercise was a true indicator, the next Marine to yell "Corpsman up!" will not get any response. Scandalous, perhaps, but we are failing to meet our mission.

There are many contributing and responsible factors, but we are not here to determine who shot John. We want to know why John was shot; and the next time he gets shot, we want to mend his poor, torn body.

We attempted to augment three Marine amphibious forces during Nifty Nugget. To augment, for those of you who do not know, means to bring Marines from reduced peacetime, in-garrison strength to full war fighting posture.

As all of you do know, the Marines think long and hard about going anywhere without medical support. This is a tribute to the Navy Medical Department, and I do not mean it as a demeaning statement about the Marines. This time, at least on paper, they headed to war without us. We didn't get our support there before they left. Even if our support had arrived, it wouldn't have been in the mix desired. There were too few of everything. The rapings we've received at the hands of budget decrements and under the weight of shore establishment realignment, coupled with the kiss of the all-volunteer force, have reduced our ability to respond.

Did you all know we don't own any Reserves? We don't. The Chief of Naval Reserve owns them. We don't know who or where they are. We tried using them with no success. We had no active troops and no Reserves; therefore, no mission.

Nifty Nugget was definitely tarnished gold, but tarnish can be removed. We have programs, we have representation, and we have all of you. We will take care of the programs and, together with OP-093, we will provide the representation. But you must manage our resources.

The critical element. Yours is the critical element. You have the folks and, like it or not, those are the folks that carry our banner to war. In part, your effectiveness as commanding officers will be measured—you can expect this to gain much more emphasis from now on—by the mobility, flexibility, and readiness of your personnel. You see to their care and feeding, training and maintenance during peacetime. But when we say to you, "We have a war; let's go," your response is critical. It can't be: "We are too busy."

I know the complexities of that. You must expand to receive returnees—and that is true in some cases. But, depending on the conflict, you might discover that the only people left at your facility are the gate guard and the housekeeper.

Ask yourself right now how fast you could draw down to that level. Where could your patients go?

These are the elements of your readiness. How many of your support special teams are ready—physically, materially, and medically knowledgeable of the role they must play in wartime? A pain in the backside, aren't they? You're overburdened with dependents, retirees, and the like. Why bug you with "maybe" problems?

The chief of surgery nags you to death about the surgical teams, doesn't he? You're "destroying his service by all this Mickey Mouse," or some similar statement. Yet these teams and their blocks represent an essential element of our operational support. Are these blocks ready to go? Have they been inventoried? Would you want to be sent to some exotic area where the temperature is zero or less with this gear? Did you listen to the anesthesiologist's complaint about the drugs and equipment? Did you raise a complaint with anyone about it?

If your responses are not positive, then you are not supporting the Medical Department or the Navy, regardless of the quality of care at your hospital. This is heavy stuff. It is not cowboys-and-Indians played by children.

We have confused you, I am sure, in the past exercise. You have been required to assemble a lot of data, very quickly, to support a "war" cooked up by the Bureau, while trying to carry out work as usual. Rough, and we knew it. And we appreciated your problems.

The folks that pay our bills—SECDEF, CNO, the fleet CINCs—have requirements. If we don't respond to them, why should they pay our bills? Gentlemen, we must meet their requirements.

We have the opportunity at this conference to discuss our problems and seek some solutions. We need your help.

It is truly my belief that if your staffs are materially and mentally prepared to support a wartime mission, they can and will give better peacetime care also. This is the real world, and these are the problems we face.

Concerns of the Enlisted Community

HMCM H.A. Olszak, USN
Force Master Chief, BUMED

I have been asked to bring to your attention the concerns of the enlisted community. I could say that we share with you common concern in areas such as the proposed pay and retirement package, the long list of benefit erosions, etc., and let it go at that. To do so, however, would be a copout, for there are specific concerns that are of importance to the enlisted community of the Medical Department as well as the Navy enlisted community overall.

CAPT Quinn

HON. Edward Hidalgo

VADM Baldwin

Some concerns may be perceived; some factual. They do, however, surface quite frequently in my travels. Let me share them with you. But first let me say at the outset that I am not here to point a finger or sit in judgment. Rather, I apprise you of these concerns with the hope that your awareness will cultivate support for change.

Housing. Let's start with a basic human need, that of adequate housing. We, as the Navy medical community, have over the past few years built many fine new patient care facilities. Marring the sites of many of these new facilities are those wornout eyesores that we call "bachelor enlisted quarters." Substandard facilities, inadequate facilities, promised or never completed self-help projects—all are of major concern to our enlisted community.

Three guidelines on bachelor housing have been issued recently that impact on this problem: (1) NAVOP 140/77, Occupancy Criteria for Assignment to Navy Bachelor Housing, which lists priorities of occupancy; (2) OPNAVINST 11101.40 of 11 Aug 1978, which lists activities with BEQs and BOQs; and (3) NAVOP 107/78, which lists minimum standards of adequacy and allows payment of BAQ if standards cannot be met.

Ladies and gentlemen, I urge each of you to become personally familiar with the contents of these guidelines. I then ask that you assess your needs accordingly and present them to BUMED. I now plead with BUMED to formalize a plan for bachelor housing modernization, based upon your needs; to push for equal competition with other Navy bachelor housing projects under the "Directed Program for Bachelor Housing Modernization"; and to seek reclama for those "fenced funds" from medical modernization that never materialized.

I ask that you, as commanding officers, take personal interest in your BEQs; that you insist on better management (most people assigned are generally castoffs); that more of the MS rating be utilized as managers; that you seek help from, and utilize the expertise of, the BEQ management teams; and that you act positively and promptly on their recommendations.

Dual standards. I am somewhat embarrassed to bring the next problem to your attention; however, it needs to be addressed. Believe me, I have had many an embarrassing encounter with my line colleagues, and I am sure you have also with your line counterparts. The question often asked is, When is the Medical Department going to join the Navy?

The reference is, of course, to dual standards—dual standards between the Navy and the Medical Department, and dual standards within our medical commands—dual standards in the area of discipline, grooming and personal appearance, weight control, and alcohol abuse.

Our junior enlisted personnel idolize the physicians for whom they work. Due to their youth, they are very impressionable and tend to follow. Consequently, the attitude and bearing of the physician has a tremendous impact on the junior enlisted community.

Many of you may have been directly involved in mediating conflict between the command master chief or assigned enlisted advisor and a physician, even at times a department head, who felt his young enlisted personnel were being harassed when told to get a haircut or improve grooming, because the physician or department head felt the issue had no bearing on the reason for existing—patient care. Or, I hear the problem voiced, "Why get on me when no one gets on him?"

These problems created by faulty attitude are real and have a tremendous impact on morale.

I understand your reluctance in dealing with the dual-standards issue; however, we have but one set of rules that applies from the CNO on down. I strongly suggest that this issue be *addressed and resolved* during this forum. It would give us a tremendous boost in morale and greatly improve our image with the line community.

Education. The young men and women we recruit into the Navy medical community have, as a rule, a high desire to be trained and to pursue part-time academic education. As our staffing drops, I hear the concern that chits for advanced schooling are held, or that personnel are openly discouraged from applying for school. Such an approach has impact on retention and long-range impact on the health care team. I ask that you monitor this problem for us.

Some commands are reluctant to consider the individual who requests a standby or trade of duty to attend an evening class. I ask that you continually encourage the pursuit of academics within your command.

The Navy enlisted community needs your help in getting us more dollars for off-duty education programs. I don't refer here to HSETC funds, but rather to the funds the Navy allows for the Navy Campus for Achievement Program, including programs such as high school studies, PACE, tuition assistance, and instructor hire programs.

The Navy is behind all other services in funding. Just listen to these funding comparisons: *FY 1976:* Army, $38 million; Air Force, $9 million; Navy, $2.3 million. *FY 1977:* Army, $64 million, Air Force, $11.5 million; Navy, $2.8 million. *FY 1978:* Army, $71 million; Air Force, $12.8 million; Navy $2.9 million.

In the harshly competitive reality of today's recruiting market, the "Community College of the Air Force," as it is called, holds a clear and distinct advantage over the Navy in offering concrete educational advantages to the young recruit. I make you aware of this concern so that, in conversations with your line counterparts, your voice will be heard in helping us achieve a funding increase. Without action soon, the programs will die.

In-service training. I hear a lot of negatives being applied to the Hospital Corps "A" School graduate from most commands I visit.

Needless to say, you are well aware of the push to shorten classroom time and the crunch on training dollars. I do not say that all is well with the curriculum, and that change is not needed.

I look back to my "A" School training, which consisted of 20 weeks of classroom time, and I often wonder if I was any better prepared than today's graduate. I do recall, however, two people who instilled more in me than any "A" School could have done, and I refer of course to my ward medical officer and ward nurse.

Unfortunately, the days of the ward-training concept seem to be over. We expect today's graduates to function flawlessly in meeting our desires when they report to work on day one.

I remind you that part of the mission of a medical center or a hospital is to teach and train, and that also means teach and train hospital corpsmen. We must overcome the reluctance on the part of the physician and the Nurse Corps officer to get involved in positive, productive in-service training programs. Many of our programs are mere paper exercises.

I ask that you insist on a continuum of training, an in-service training program that is positive and career enhancing, and that involves the professional side of the house. Attendance must be mandatory; lesson plans must be standardized and planned well in advance. We must use the talent within our commands to enhance the well-being of all those assigned to the command.

Utilization of personnel. Our enlisted women still complain of paternalism, and many feel they serve just one purpose—that is, to act as standbys. Women in the service are here to stay, and in ever-increasing numbers. Your help is needed in breaking this stereotype and in providing full utilization, based on capabilities, in nontraditional areas.

Utilization and job satisfaction strike at the very reason we have a problem in retention. This cuts across all our enlisted pay grades, Navy-wide. As we go about "aging the force"—that is, time between advancements is becoming longer—we need your help in providing within your commands new challenges, new roles for our enlisted force. Of particular concern is the high number of well-trained personnel that we lose at the E-5 and E-6 levels, who fall within the 8- to 12-year, 8- to 14-year service group.

As we shift to the PASS concept and get out of the personnel and secondary administrative functions that we have been accustomed to, we must provide a place in the patient care setting for those 8425 NEC advanced hospital corpsmen who return to us from sea.

Our senior enlisted personnel at the E-8 and E-9 levels are in dire need of a management training course. Thanks to the progressive leadership of the Surgeon General, this program may be on track early next year.

We need your help in identifying billets within your commands that our E-8 and E-9 petty officers can fill in relation to the new role definitions recently approved by the Chief of Naval Operations, and in which they can find challenge and job satisfaction.

Chain of command. Our chain of command must be strengthened. You must make it known within your command that the petty officer structure starts at the E-4 level, not at the E-7 level; that there is a difference in how an E-4 and an E-5 are assigned tasks, in comparison with an E-2 and an E-3; that responsibility, authority, and accountability go with the pay grade; and that your petty officers can count on you for

backing when needed.

I feel that our leadership and chain of command have been weakened because we have forgotten that as human beings we sometimes fail, and failing is no longer acceptable. As a result, the young petty officer, when confronted with a problem—afraid of failing and unsure of backing by the chain of command—does absolutely nothing, and this philosophy continues on up the chain until every problem comes to rest in your office, rather than being resolved at the lowest possible level. Your insistence that your staff assign the right petty officer pay grade to the task required, and then your pledge of full backing, would do much to rectify this situation.

Evaluations. Enlisted evaluations are continually taking on greater importance and, for the most part, are poorly handled and get little attention in many of our commands.

The system itself is poor. Depending on pay grade, we use three different evaluation sheets and a multitude of abbreviations to write an evaluation. Without a BUPERS manual at one's side, it is virtually impossible to know how to begin writing.

The problem has been recognized. In fact, a panel of fleet and force master chiefs has recommended change that ultimately will result in a new, single, simplified evaluation sheet. Beginning in early 1979, BUPERS will handle and scrutinize enlisted evaluations in the same manner as officer fitness reports.

A major problem is that evaluations are not forwarded to BUPERS on time, and that narratives seldom support the marks assigned. Your command master chief can be a big help to you in this area. Depending on the size of your command, he or a group of senior petty officers under his direction should review all evaluations for content.

Recognition. Recognition and the feeling of belonging to the team—How can this be accomplished? By anything from addressing people by name, to commending by letter, to spending a few dollars for enlisted travel and TAD, to awarding of medals.

'People' programs. We also voice concern over how our traditional "people" programs are handled.

- Career counselors—Some commands have none; some do not have enough to cover the number of people assigned. Too many are given the assignment as a collateral duty and have no time to serve the enlisted staff. In some commands it takes a month or longer to get an appointment to talk with the counselor.

I ask that you review NAVPERS 15878, the Retention Team Manual that was issued in October 1977. It gives clear guidelines and sets responsibilities on all key members of the command. Your help is needed.

- Housing referral offices—These are generally not staffed with quality people. If civilianized, these offices are usually the first to face cuts. The offices usually are not properly supervised, and referrals to the local community are not up-to-date. We need your help.
- Sponsor program—In many commands, it is totally ignored. We need your help.
- Indoctrination program—This is a very critical issue, for first impressions are often lasting; yet in many commands very little is being done in this area. We need your help.

Ladies and gentlemen, these are some of the major concerns voiced by the enlisted community. I am sure the issues addressed are not new. You have heard them before, and that is what is of most concern. We have been giving lip service, without action, for too long.

I feel we are at the crossroads. The time for action is now. For one thing is certain: the source of supply of accessions is very rapidly dwindling. We need to devote our attention, our time, and some money today to the people who support our mission, for if we don't act now, we won't have the people to support the mission in the days ahead.

A Special Role

The Honorable Edward Hidalgo
Assistant Secretary of the Navy for
Manpower, Reserve Affairs, and Logistics

I think this is the right stage in my life, and the right scenario, to make a very, very deep confession to you. In the next go-around, what I would like to be is exactly what you are—a physician. (I am a frustrated lawyer.)

I've thought of it very often. There are certain wonderful comparisons between your profession and mine. Both professions are analytical; they are deductive. In both, you need facts before you can move.

But we lawyers deal with very mundane things. You people deal with diagnosis that can save life; with surgery that can save life; with those incredible factors that make up the human being.

Your role to me is very special, and therefore I can assure you that I have dealt with such of your problems as have come before me with the deepest interest and the utmost sincerity, and have had wonderful rapport with your Surgeon General.

That's by way of preface.

The medical care problem seems to be at a very severe crossroads. In greater or lesser degrees, the three services are being hard put to it to meet their ever-so-important responsibilities in this area, and the exigencies and shortfalls are not going to have an overnight cure. This means that you have to use—and count on me for any help I can ever give—your resources to the fullest possible measure, and with the greatest degree of efficiency.

In terms of this, I've had the privilege to work closely with VADM Arentzen, who took a bold initiative with

regard to the reorganization of BUMED, supported, as you know, by an excellent study by Cresap, McCormick, and Paget. Not that reorganizations, per se, achieve the panacea we search for. But they make it viable for us to use our resources more effectively. In other words, if we've got the wrong organization, we know we can't do it; if we've got the right one, we have a chance of doing it.

This reorganization, as it's planned, should liberate the Surgeon General, the Chief of BUMED, to do the things that should have top priority, and should locate and position everyone for maximum effectiveness.

Let me just mention briefly a recent voyage that I took. I went to Hawaii first; then to Yokosuka, Seoul, Okinawa, Subic Bay; then down to Rome to see the Sixth Fleet.

You know, I think all the pessimism we hear about resides in Washington. Our overseas commanders and men and women don't share this pessimism, thank God. Everywhere I went, I got the same message: readiness, very high; morale, very high; reenlistments, very high.

Now just think of the vital role that you play in that "morale, very high." It's absolutely key. The skill of your endeavors; your empathy and sympathy, and that of the people who work with and for you—these things are key to the morale of which I speak.

I came back very strongly impressed with the huge responsibilities that our great country has today—with its presence everywhere, its might everywhere. Whether it's Korea or Japan—whether it's the 20-odd thousand Marines on Okinawa and Iwakuni or the Sixth Fleet—there's that American umbrella.

You have every reason to join me in this great sense of pride that our country is a great power—a great power discharging its responsibilities fervently, efficiently, and masterfully.

The Navy Personnel Situation

VADM R.B. Baldwin, USN
Chief of Naval Personnel

I'm going to talk rather broadly about the personnel situation in the Navy, rather than just focus on the medical/dental health services aspect of things, although I recognize your focused interest in that part.

I think there is a very strong kinship and a necessary partnership between what used to be BUPERS, until we reorganized—and still is BUPERS, as we understand it—and BUMED. Both organizations are very deeply in the "people" business, and we must maintain a good, cooperative partnership attitude. I think that is more important than ever now, when we do not have the personnel resources to which, perhaps, we became accustomed in the past. We've got to preserve and grow our own, so to speak.

Let me talk about the front end of our personnel program—recruiting. We're not doing well. We have had shortfalls in each of the last 20 months save one—last July was the only month in which we made our quota. We came in 1,100 short in October.

Quite clearly, the market is tougher than the planners predicted when they put earlier budgets together, and we're embarked on a crusade to increase recruiter resources. I think that, clearly, is indicated.

Retention. The middle part of the equation is really more worrisome. The reason we're not making our recruiting numbers, taken in the whole context, is that we're not retaining enough and are putting too much of a load at the front end for the health of the organization, really. Our second-term retention falls somewhere in the 50-60% ballpark when it ought to be in the 70-80% ballpark. That gives you an order-of-magnitude idea of that sag in the middle of our organization where you need your main strength—where you've got some time and experience on the job.

This is a relatively recent happening. Four or five years ago, we had retention up in that area, from people in that particular age group. It's going down, and that's a clear signal to us that we have to do some dramatic things to turn the situation around.

In this regard, you all are a particular part of the action. These are people who have been in the force long enough to make a career decision, and not enough are making it. I just ask you to keep this in mind, in all your actions and interactions with people in uniform and their families. You are a very big factor in the decision they make.

Compensation. Going to the end of the personnel structure—retirement considerations—I'm sure that all of you are wondering what is happening to the recommendations of the President's Commission on Military Compensation. It reported out, with much fanfare and not too good publicity, last spring. Since that time, there has been a lot of interplay between us, the services, and SECNAV in looking at the report and giving it particular pushes this way and that way that we think would make a good thing out of it.

We are getting close to a decision point. Just over the weekend, ASD Manpower put out a kind of analysis paper. They really didn't come down on their recommendation, but they came to us and clearly want our final input as to what kind of system we want.

Our view of current compensation, looking very practically at our service, is that it is not working to the degree that it should. We are not attracting enough people in recruiting—we can prove that by simply reading the monthly take—therefore, basic attractiveness is not there for the young fellow.

The sag in our second-term retention says that there is not enough compensation for what we are asking this group of people to do. That means we must make more compensation visible at an earlier age—do some front loading.

We are not in a position to endorse any plan that has as one of its assumptions that it is necessary to save money in terms of compensation. We think it would be folly for our leadership to say, "Yes, my force can take a pay cut," when we are not keeping people in the numbers we need.

So, basically, the CNO and the Secretary are looking for a compensation package that is a very highly probable bet to be more attractive to the full spectrum of personnel than the one we have today. They will be very surprised if such a package can be generated at costs less than the current system.

The Secretary of Defense has not indicated his primary consideration with regard to such a compensation package, but I think he will give every thoughtful consideration to the plan and not act precipitously on this subject.

If nothing else has been established in the back-and-forth on this compensation plan, there has been a clear realization that the Navy needs more help in the area of compensation than do the other services. The Air Force clearly has a full structure, and you can understand why they are very anxious not to disturb the status quo. The Army and the Marine Corps are not in as favorable a position as the Air Force, but they do not seem to feel shortages in the middle grades quite as severely as we do. However, we intend to point out that the Navy's needs are of such importance that they deserve special attention and this will be our position in the bargaining that will take place at all levels of the government as we go forward for such things as bonuses and special compensation for the special needs of the Navy.

I won't make a prediction as to what will happen on the compensation plan, other than to say that your Secretary and your CNO will be hanging very tough in fighting for a plan that is attractive and will stimulate people, rather than one that will turn them off. Whatever comes out of this, it's going to take some complicated legal work in drafting, with a new Congress coming in—particularly if there is a significant change from the current system.

I think we'll have a long session with Congress before anything really happens. So don't look for something to happen overnight, and please calm people down who are concerned that the system our people in service have gotten used to is going to be changed radically. Again, the message has come across loud and clear that there is considerable nervousness among people now on active duty that they're going to have some changed expectations. Those feelings will be respected.

Women aboard ships. Women in the Navy have gotten a lot of publicity lately because Congress changed the law that had very severe restrictions on utilization of women in ships. We now have the authority to place women aboard ships, with the exception of combatant types, and we can in fact place them in combatant types for temporary duty periods associated with their assignments, provided the unit is not projected to go into combat at that time.

Some of the first women are reporting aboard ships down in Norfolk, and San Diego ships will follow with both officer and enlisted personnel shortly. We'll see how this goes.

We're not involved in a social experiment here—I want to make that clear. This is being done for pragmatic reasons—to ensure that we are making the best use of people available to the Navy in light of the fact that we are not now attracting the numbers we would like to attract. And being able to do that in the future is going to be even tougher as the numbers of people diminish because you gentlemen and your predecessors have gotten so smart in educating the world to the dangers of overpopulation.

We've gone about this in a careful, thoughtful sort of way. I think that if everybody acts maturely and responsibly, it will turn out to be a beneficial move and will give us some flexibility that we have not had.

Organizational changes. I'd like to talk a little bit about my own organization and some organizational changes that have taken place just recently.

The Navy has traditionally had a separation between its military personnel and its civilian personnel in terms of chain of command. Civilian personnel were formerly administered through the Navy Secretariat. Now that has been changed to run through the CNO chain of command, and what was formerly the Office of Civilian Personnel has now migrated into OP-01.

Another significant change has been the investment of considerable responsibility for training, planning, and programming in OP-01. The Chief of Naval Education and Training continues organizationally, but he is an executor and not double-hatted also as a planner, which in the past put him in an untenable position, in a way.

I've always felt that we went too far when we established CNET in divesting the CNO of some of the responsibilities that only he should carry. That responsibility has now been restored; OP-01 is the overall training coordinator in town. We aren't going to try to run school houses from Washington, in the old perceived command mode, but we certainly are going to try to ensure that the CNO's responsibilities of laying out training requirements are coordinated and put in proper priority here at the headquarters level.

Those are a few current issues of a general nature that I wanted to chat with you about. I do have close ties with the Surgeon General. As I said, I think both of us realize we have inseparable interests in many of the things that are going on today. I intend to maintain these close ties as time goes along so that we can move forward together on issues that affect our people.

Notes & Announcements

In memoriam . . . CDR Walter A. Bloedorn, MC, USN (Ret.), former Navy physician, and former dean of George Washington University's medical school, died 28 Nov 1978, at age 92.

Dr. Bloedorn was born in North Platte, Neb., and graduated from Creighton University's medical school, Omaha, Neb., in 1909. He then joined the U.S. Navy Medical Corps and had duty assignments in China, Japan, Philippine Islands, and as executive officer and consultant in medicine at the Naval Medical School and Hospital in Washington, D.C. During World War II, Dr. Bloedorn helped establish the Army Special Training and Navy V-12 programs for drafted college students.

By 1916, Dr. Bloedorn had received a bachelor and master's degree from George Washington University. He joined the university faculty as professor of tropical medicine in 1926 and retired from the Navy as commander in 1928. During his naval career, Dr. Bloedorn wrote articles on many subjects including cholera, drug addiction, venereal diseases, meningitis, heart studies, the annual physical examination, gunshot wounds, hysteria, and "The Barbarous Custom of Smoking."

In 1930, he became professor of medicine and assistant dean of George Washington University's medical school. In 1932, he was named medical director of the university's hospital and seven years later became dean of the medical school. He held both positions until his retirement in 1957. In addition to his hospital and medical school work, Dr. Bloedorn had maintained a private practice in internal medicine until closing his Washington office in mid-1970.

Dr. Bloedorn was president of the Association of American Medical Colleges in 1947-1948, and of the National Board of Medical Examiners in 1957. He was a fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

Dental continuing education course . . . The following dental continuing education course will be offered in May 1979:

Eleventh Naval District, San Diego, Calif.
Periodontics — 14-16 May 1979

Applications should be submitted six weeks before the course begins to: Commandant, Eleventh Naval District (Code 37), San Diego, Calif. 92132.

USUHS graduate degree programs . . . The Uniformed Services University of the Health Sciences is offering accredited graduate degree programs in the basic medical sciences.

Master's and doctoral degree programs in anatomy, medical physiology, microbiology, pharmacology, and physiology are currently open to qualified military and civilian applicants. Graduate programs in biochemistry and preventive medicine are being developed, with the admission of students scheduled for September 1979. These programs of study are designed for outstanding individuals with a strong commitment to permanent careers in the basic medical sciences.

Deadline for applications for the Fall 1979 semester is 1 March 1979.

Selection of students will be based on undergraduate and postgraduate academic records, letters of recommendation, and results of the Graduate Record Examination. Specific graduate studies may impose additional requirements for admission.

Military applicants must obtain the approval and sponsorship of their military department and will incur an obligation for additional service.

USUHS graduate programs are intended to foster independent scholarship, originality, and competence in research, teaching, and professional service. Graduate students will serve as teaching and research assistants in support of the USUHS School of Medicine.

Graduate courses will be directed by members of the medical school basic sciences faculty and will be conducted in new laboratories designed to support a wide variety of research projects. Special resources include high resolution scanning and transmission electron microscopes, biohazard containment laboratories, a central animal facility, computer support, and a medical library.

The USUHS was established by Congress in 1972 and has a current enrollment of 99 medical students. The campus is located in Bethesda, Md., adjacent to the National Naval Medical Center and the Armed Forces Radiobiological Research Institute and close to the National Library of Medicine and the National Institutes of Health. Various affiliations with these institutions and the Walter Reed Army Medical Center and the Armed Forces Institute of Pathology, provide additional resources to enhance graduate education.

For further information, write: COL John W. Bullard, MSC, USA, Assistant Dean for Graduate Education, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Rd., Bethesda, Md. 20014.

CARDIAC LIFE SUPPORT PROGRAM AT JACKSONVILLE . . . NRMC Jacksonville has launched a drive to get all medical and paramedical personnel certified by the American Heart Association in advanced cardiac life support (ACLS). The regional medical center, which already had an active basic cardiac life support program, recently inaugurated a two-day ACLS-provider course, for physicians, nurses, physician's assistants, and EMTs, taught entirely by Navy personnel.

The course comprises two days of intensive training in use of defibrillators, IV techniques, endotracheal intubations, acid-base balance, and recognition and treatment of cardiac arrhythmias. It culminates in a practical test involving a simulated cardiac arrest.

The Jacksonville program eventually will provide a tiered net, throughout the entire medical region, of qualified basic and advanced cardiac life support personnel who can respond within minutes to cardiac arrests or other acute medical emergencies.

NEW ORLEANS HOSPITAL LEASED . . . The Navy has leased the F. Edward Hebert Hospital—formerly NRMC New Orleans—to Westbank Medical Service, a private corporation that will use the facility to provide such services as an OB-GYN clinic, special nursing for elderly patients, physical therapy, alcohol rehabilitation, and care of terminally ill patients. Westbank also runs the Jo Ellen Smith Memorial Hospital a couple of miles from the former naval regional medical center.

Under the terms of the lease, the Navy will receive $480,000 per year in rent—and more if Westbank's revenues from the project rise. The Navy will continue to operate its outpatient clinic on the first floor of the main hospital building, and retains the right to take over the entire hospital in the event of a national emergency.

NEWPORT DENTAL CENTER DEDICATED . . . The new regional dental center at the Naval Education and Training Center, Newport, R.I., was officially dedicated on 7 Dec 1978.

The $1.7 million facility, equipped and staffed to provide the utmost in modern dental care, includes 17 dental treatment rooms, a central sterilization room, a recovery room, a conference room/library, and administrative spaces. Support services include a regional prosthetics laboratory, a dental equipment repair unit, and a regional supply storeroom.

In addition to providing complete dental services to fleet- and shore-based personnel in the Narragansett Bay area, the center is headquarters for all naval dental facilities in the northeastern United States. Branch clinics are located at the Naval Submarine Base, New London, Conn.; the Naval Air Station, South Weymouth, Mass.; the Naval Air Station, Brunswick, Me.; the Naval Security Group Activity, Winter Harbor, Me.; the Naval Communications Unit, Cutler, Me.; the Naval Shipyard, Portsmouth, N.H.; and the Naval Administrative Unit, Scotia, N.Y.

UNIFORM CHART OF ACCOUNTS SEMINARS . . . BUMED representatives recently conducted Uniform Chart of Accounts training seminars at San Diego, Oakland, Virginia Beach, Great Lakes, and Pensacola. The three-day seminars covered a wide variety of UCA topics, including the Expense Assignment System and automated source data collection.

Detailed UCA implementation manuals will be provided to all activities next month; however, it was felt that earlier, detailed exposure to UCA was necessary for adequate preparation for the 1 Oct 1979 worldwide implementation date.

USU GRADUATE EDUCATION PROGRAMS . . . Graduate programs in Anatomy, Medical Psychology, Microbiology, Pharmacology, and Physiology have been approved by the Uniformed Services University of the Health Sciences' Board of Regents and are now in operation. Graduate programs in Biochemistry and Preventive Medicine are now being developed, and plans are to admit students to these two programs in September of this year.

USUHS invites qualified applicants who have a requirement for this level and type of training. Active-duty Uniformed Services personnel who are eligible to apply and who are approved and sponsored in graduate training by their parent service will be given preference in the selection process. Interested individuals should contact COL John W. Bullard, Ph.D., MSC, USA, Assistant Dean for Graduate Education, USUHS, 4301 Jones Bridge Rd., Bethesda, Md. 20014.

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